STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016732	A. BUILDING: _____ B. WING _____	C 09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE SENIOR LIVING	2330 BRUCE STREET NEENAH, WI 54956

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments On 09/15/2025 with additional information gathered through 09/26/2025, Surveyor conducted a standard survey and two complaint investigations. As a result two deficiencies were identified. Two of 2 complaints were substantiated. Census: 20	N 000		
N 432	83.38(1)(h) Medication administration. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on interviews and record review the facility did not provide medication administration services appropriate for 1 (Resident 1) of 1 resident reviewed. Resident 1's Warfarin medication was to be re-started on 08/02/2025 following a medical procedure. The Warfarin medication was not transcribed onto the August 2025 eMAR and the resident went 15 days throughout the month of August, without receiving the medication. Additionally, an INR (international normalized	N 432		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016732	A. BUILDING: _____ B. WING _____	C 09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE SENIOR LIVING	2330 BRUCE STREET NEENAH, WI 54956

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 432	Continued From page 1	N 432		

ratio) blood test was ordered by the physician on 08/07/2025 for further monitoring/dosing of Resident 1's Warfarin medication. The INR test was not competed until 08/13/2025, 7 days later.

Findings include:

According to http://www.nlm.nih.gov/medlineplus/druginfo, "Warfarin is used to prevent blood clots from forming or growing larger in your blood and blood vessels. It is prescribed for people with certain types of irregular heartbeat, people with prosthetic (replacement or mechanical) heart valves, and people who have suffered a heart attack. Warfarin is also used to treat or prevent venous thrombosis (swelling and blood clot in a vein) and pulmonary embolism (a blood clot in the lung). Warfarin is in a class of medications called anticoagulants ('blood thinners'). It works by decreasing the clotting ability of the blood...A prothrombin time test measures how quickly your blood clots. If you take a blood-thinning medication such as Warfarin, your prothrombin time test results will be expressed as a ratio called the international normalized ratio (INR). If you are taking Warfarin to prevent blood clots, your provider will most likely choose to keep your INR between 2.0 and 3.0."

On 08/28/2025, the department received a concern regarding medication administration.

On 09/15/2025, Surveyor reviewed Resident 1 medical record. The resident was admitted to the facility on 09/27/2024 with diagnosis to include; heart failure, myocardial infarction, intracardiac thrombosis, long term use of anticoagulants, and absence of right leg above knee. Per record review, the resident was able to make needs

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016732	A. BUILDING: _____ B. WING _____	C 09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE SENIOR LIVING	2330 BRUCE STREET NEENAH, WI 54956

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 432	Continued From page 2	N 432		

known, was his/her own person and staff administered and managed all of Resident 1's medication. In addition, the record indicated APNP (Advanced Practice Nurse Prescriber)-B was Resident 1's physician and had written an order for Resident 1 to receive Warfarin 7.5 mg daily.

A physician visit note for Resident 1 dated 07/21/2025 indicated, "Upcoming appointments: 08/01/2025 EGD (esophagogastroduodenoscopy)...Hold Warfarin x 5 days prior...Collaboration on medication orders prior to EGD scheduled for 08/01..."

Review of Resident 1's "Bluestone Bridge Communication Portal" documented the following:

~07/21/2025- APNP-B wrote, "HOLD Warfarin 07/27/2025-08/01/2025."
~08/05/2025- APNP-B wrote, "The Warfarin was supposed to be restarted on 08/02...Please restart tonight and recheck INR again on Thursday (08/07)."
~08/08/2025- APNP-B wrote, "I did request an updated INR TODAY, due to a very low level due to need to hold last week."
~08/12/2025- APNP-B wrote, "INR was due to be updated last Thursday (8/07). Still no results. Please update ASAP."
~08/13/2025- Lead Medication Aide C wrote, "I just checked the INR. Please advise and send over for pharmacy to get over today."
~08/13/2025- APNP-B wrote, "Still HOLDING the Warfarin? There was an order to restart the 7.5 mg on 08/05 and pharmacy has been continuing to send 7.5 mg..."

A physician visit note for Resident 1 dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016732	A. BUILDING: _____ B. WING _____	C 09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE SENIOR LIVING	2330 BRUCE STREET NEENAH, WI 54956

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 432	Continued From page 3	N 432		

08/18/2025 indicated, "...Significant concern for inappropriate management of Warfarin and INR levels by facility without responses to Bridge messages regarding need for clarification of current Warfarin dosing, holding Warfarin long beyond hold date of 08/02/2025 and not following through with orders for increased frequency of INRs due to subtherapeutic levels and incorrect Warfarin dosing. At this time, Warfarin has been restarted at a 7.5 mg daily for the past 5 days. Will ensure INR is rechecked today and dosing adjusted based on levels...Records from the Bluestone Bridge communication portal were reviewed today with the following updates: Facility errors with holding Warfarin for EGD procedure affecting INRs. Order to hold Warfarin 7/27-8/1 for 8/1 procedure, resume 8/2 and recheck INR on 8/4. Updated INR 8/5 of 1.1 noting Warfarin still being held. PCP reiterated need to restart previous dosing at 7.5 mg daily and recheck INR on 8/7 without results posted. 8/8 Bridge message reminding facility of need for updated INR without response. 8/12 Bridge message reminding staff of overdue INR without response. 8/13 INR reported by facility of 1.1 and notation of ongoing hold of Warfarin. PCP reordered the 7.5 mg daily and sent message to confirm the Warfarin was actually still being held, with no response from facility. Review of facility's electronic record: ...Warfarin documented as administered this month starting 8/13 only with last dose being 7/27 (as ordered)...Today's Medications: ...Warfarin 7.5 mg tablet every day for 7 days... "

A review of Resident 1's eMAR (electronic Medication Administration Record) for August 2025, indicated Warfarin 7.5 mg was not transcribed to the eMAR or administered to the resident from 08/02/2025 to 08/12/2025 (11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016732	A. BUILDING: _____ B. WING _____	C 09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE SENIOR LIVING	2330 BRUCE STREET NEENAH, WI 54956

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 432	Continued From page 4 days). On 09/15/2025, Surveyor reviewed Resident 1's medical record. The medical record did not contain the results of Resident 1's INR for 08/07/2025. Additionally, no documented communication with the resident's physician and/or other health care provider was located in the medical record regarding an INR result for 08/07/2025. The facility did not obtain Resident 1's INR blood test until 08/13/2025, 7 days later. Review of Resident 1's "Bluestone Bridge Communication Portal" documented the following: ~08/26/2025- APNP-B wrote- "INR has dropped again to extremely subtherapeutic. With significant suspicion of ongoing Warfarin error, phone call was placed to the facility who indicated full card of Warfarin did remain in the cart and not administered over the past week. [Resident 1] has ongoing atrial fibrillation with an active history of development of blood clot in [his/her] heart, which necessitates [s/he] be on a blood thinner for the rest of [his/her] life to avoid recurrence. Warfarin is a very dangerous medication that requires very close attention to administration, blood levels, and adjustment of doses to ensure efficacy without adverse effects. It CANNOT just be restarted at this time with [her/him] now seemingly receiving 0 to very few doses since hold order was placed on 7/27/25..." ~08/27/2025- APNP-B wrote- "In collaboration with family and pharmacy in regard to [Resident 1's] safety with medication options and administration, at this time, ...We are going to transition Warfarin to Eliquis at this time...D/C Warfarin. Start Eliquis 5 mg."	N 432		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016732	A. BUILDING: _____ B. WING _____	C 09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE SENIOR LIVING	2330 BRUCE STREET NEENAH, WI 54956

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 432	Continued From page 5 A review of Resident 1's August 2025 eMAR indicated the Warfarin medication was not transcribed to the eMAR or administered to the resident from 08/21/2025 to 08/24/2025 (4 days). A incident report for Resident 1 dated 08/25/2025 indicated, "Resident had a medication error on 08/25/2025. Staff asked WC (Wellness Coordinator) why [Resident 1's] INR needed to be done because [s/he] had Warfarin in the overflow drawer. WC and staff realized resident did not receive [his/her] scheduled doses of Warfarin on 08/21, 08/22, 08/23 or 08/24/2025. WC and staff did resident's INR and sent results over to PCP..." A physician visit note for Resident 1 dated 09/15/2025 indicated, "Records from the Bluestone Bridge Communication Portal were reviewed today with the following updates: Following identification at last visit 8/18 significant errors regarding non administration of Warfarin following hold around 8/2/25 with education of "WC (Wellness Coordinator)" and medication tech further noted on 8/26 INR was reported at 1.1 with report [Resident 1] was receiving a 7.5 mg daily. Phone call to facility with suspicion of likely not receiving Warfarin with very subtherapeutic INR indicated medication card was missing only one dose from the past week. With extreme concern for [Resident 1's] safety and in collaboration with [her/his] family and pharmacy, [Resident 1] was transitioned at that time to Eliquis...Concerning medication errors by facility for one full month throughout 8/2025 in regard to Warfarin significantly increasing risk of recurrent thrombosis. No signs of DVT or PE at this time. Warfarin was transitioned to Eliquis as of late August to reduce risk of further medication errors..."	N 432		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016732	A. BUILDING: _____ B. WING _____	C 09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE SENIOR LIVING	2330 BRUCE STREET NEENAH, WI 54956

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 432	Continued From page 6 On 09/15/2025 at 2 PM, Surveyor interviewed Resident 1 privately in his/her room regarding care and treatment provided by the facility. Resident 1 stated to Surveyor, "I didn't always get my Warfarin medication." Resident 1 verified following his/her EGD procedure on 08/01/2025 s/he did not receive his/her Warfarin medication as ordered. On 09/15/2025 at 11:50 AM, Surveyor interviewed Resident 1's Family Member D regarding Resident 1's Warfarin medication. Family Member D stated, "[Resident 1] was supposed to stop taking Warfarin five days before [his/her] EGD procedure on 08/01/2025 and then resume on 08/02/2025. [Resident 1] did not receive [his/her] Warfarin medication for weeks following the EGD procedure, which put [Resident 1] at risk for blood clots...It was not acceptable the way the facility handled [Resident 1's] Warfarin medication and INR level." On 09/15/2025 at 1 PM, Surveyor spoke with Lead Medication Aide C regarding Resident 1's Warfarin medication in 08/2025. Lead Medication Aide C verified Resident 1 has not received his/her Warfarin medication from 08/02/2025 until 08/12/2025, because the Warfarin medication was not transcribed onto the eMAR. Surveyor then questioned Lead Medication Aide C who was responsible for transcribing medication orders to the eMAR. Lead Medication Aide C stated, "[WC-A] and I have access to transcribe medication orders to the eMAR, but we have to wait until the medication arrives in the building. [Resident 1's] Warfarin medication arrived, but the PM shift staff didn't tell [WC-A] the medication was in the building so [Resident 1's] Warfarin medication didn't get transcribed or passed. I	N 432		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016732	A. BUILDING: _____ B. WING _____	C 09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE SENIOR LIVING	2330 BRUCE STREET NEENAH, WI 54956

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 432	Continued From page 7 know after the medication error [WC-A] talked to the staff involved about letting [her/him] know right away when a medication arrives." On 09/15/202 at 1:50 PM, Surveyor spoke with WC-A regarding the above information. WC-A confirmed Resident 1's Warfarin medication was not transcribed onto the August 2025 eMAR and the resident went 15 days without receiving the medication. WC-A further verified Resident 1's INR level was not completed on 08/07/2025 as ordered. On 09/15/2025, Surveyor spoke with APNP-B. APNP-B indicated Resident 1 was to stop taking the Warfarin medication from 7/27/2025 until 08/01/2025 for an EGD procedure. Following the EGD procedure the Warfarin medication was supposed to resume on 08/02/2025, but didn't. APNP-B stated, "I asked for [Resident 1's] INR level to be completed on 08/07/2025 and it was not done timely." APNP-B went on to say, "I've posted messages on the "Bluestone Bridge Communication Portal" which [WC-A], [Lead Medication Aide C] and [Executive Director E] have access to and can see the messages and respond." APNP-B continued to say, "On 08/18/2025, I was at the facility and went to the med cart with [WC-A] and we found three cards with weekly doses of [Resident 1's] Warfarin medication not administered. [WC-A] told me the Warfarin was not administered because the medication was not place in the correct medication drawer. I provided education to staff on the importance of the medication and how [Resident 1] is at risk for blood clots and then ordered another week of the Warfarin medication. On 08/26/2025, I noted [Resident 1's] INR level was low and called and questioned [WC-A] if Resident 1 had been receiving [his/her] Warfarin	N 432		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016732	A. BUILDING: _____ B. WING _____	C 09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE SENIOR LIVING	2330 BRUCE STREET NEENAH, WI 54956

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 432	Continued From page 8 medication. [WC-A] verified there was only one dose taken out of the Warfarin weekly dose card." On 09/15/2025, 09/16/2025 and again on 09/22/2025, Surveyor requested all documentation regarding the above medication errors. Surveyor was provided with two "Counseling/Disciplinary Notices" dated 08/27/2025. The first notice was for Medication Aide F and indicated, "...2. Reason(s) why counseling/disciplinary action is necessary...Final write-up due to not contacting WC to put Warfarin in the MAR for resident and then not giving the resident the needed medication...3. Corrective action: Final write-up and next offence will be termination. It's so important to always communicate with your WC on medications that need to be entered..." The second notice was for Caregiver G and indicated, "2. Reason(s) why counseling/disciplinary action is necessary...Write-up due to not contacting [WC-A] about not being able to find a medication for a resident. 3. Corrective action: Counsel due to importance of communicating with WC. Next offense will be a final write-up and/or termination." In conclusion, Resident 1's Warfarin medication was not re-started following a medical procedure on 08/01/2025. Throughout the month of August 2025, Resident 1 went 15 days without receiving the Warfarin medication which placed the resident at increased risk for blood clot formation. Additionally, the facility did not ensure Resident 1's INR lab test was completed as ordered by the physician to ensure proper monitoring and dosing of the Warfarin medication.	N 432		
Y3244	50.09(1)(L) Care	Y3244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016732	A. BUILDING: _____ B. WING _____	C 09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE SENIOR LIVING	2330 BRUCE STREET NEENAH, WI 54956

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y3244	Continued From page 9 (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to (l) Receive adequate and appropriate care within the capacity of the facility. This Rule is not met as evidenced by: Based on observation, staff interviews and record review, the provider did not ensure Resident 1 and Resident 2 received proper care and treatment within the capacity of the facility. Resident 1 utilized the facility's call alarm system for personal services. Staff did not respond to Resident 1's call alarm timely and Resident 1 had to wait over 25 minutes for assistance with personal cares. On 05/17/2025, Resident 2 sat up in his/her wheelchair overnight because s/he refused to allow Medication Aide F to provide personal cares and put him/her to bed. On 05/18/2025, during the AM shift Resident 2 continue to sit-up in [his/her] wheelchair and had a bowel movement. Staff did not assist Resident 2 with incontinence	Y3244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016732	A. BUILDING: _____ B. WING _____	C 09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE SENIOR LIVING	2330 BRUCE STREET NEENAH, WI 54956

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y3244	Continued From page 10	Y3244		

cares because the resident refused cares. Resident 2 did not ambulate, was incontinent of bowel, required staff assistance with personal hygiene, and had a history of wounds to his/her buttocks. The provider did not evaluate the resident's refusals, in an attempt to determine the reason for the refusals, offer/implement new interventions or update the ISP (Individualized Service Plan) to ensure Resident 2's health was monitored and cares were provided.

Findings include:

RESIDENT 1

On 09/15/2025 at 2 PM, Surveyor observed Resident 1 sitting in her/his bed, with a call cord mounted to the wall near the head of the resident's bed. Surveyor interviewed Resident 1. Resident 1 indicated s/he has resided in the facility for about a year and utilizes her/his call cord for assistance with personal services. Resident 1 stated, "I put my call light on to get help with changing my incontinent brief...I also use it to get help with dressing because I can't do it by myself...Many times, I've waited over 25 minutes for staff to answer my call...Sometimes I can catch someone in the hallway walking by to help me. It happens daily especially around shift change. A few weeks ago [Caregiver G] answered my call light, and [s/he] noticed I was waiting almost an hour for help." During the above interview with Resident 1, Family Member H was present in the room. Family Member H stated, "I visit daily, and [Resident 1] waits an hour at times for help when [s/he] pulls the call cord. [Resident 1] typically pulls the call cord when [s/he] wants [his/her] brief changed or the bed pan. I've witnessed this at least twice in the past week...Generally, [Resident 1] waits about

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016732	A. BUILDING: _____ B. WING _____	C 09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE SENIOR LIVING	2330 BRUCE STREET NEENAH, WI 54956

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y3244	Continued From page 11 30 minutes before staff come in to help." On 09/15/2025, Surveyor reviewed Resident 1 medical record. The resident was admitted to the facility on 09/27/2024 with diagnosis to include heart failure, diabetes, muscle weakness and absence of right leg above knee. Per record review, the resident was alert and oriented, able to make needs known, and was his/her own person. Review of Resident 1's ISP (Individual Service Plan) dated 05/20/2025 indicated, the resident was incontinent of bowel and bladder, required assistance with toileting, bathing, hygiene and dressing. Additionally, the ISP indicated Resident 1 is ambulatory with the wheelchair, required one staff assistance for transfers with a slide board and "[Resident 1] will ring when [s/he] wants to transfer from the wheelchair to bed." Review of the facility's call alarm history from 07/01/2025 through 09/15/2025 verified Resident 1's concerns of waiting a long time for assistance. The call alarm history for Resident 1 showed the following wait times for assistance: *07/01/2025 at 2:24 AM response time 1 hour 39 minutes *07/01/2025 at 6:37 AM response time 49 minutes *07/01/2025 at 12:36 PM response time 31 minutes *07/01/2025 at 4:18 PM response time 1 hour 53 minutes *07/01/2025 at 11:36 PM response time 37 minutes *07/02/2025 at 7:51 AM response time 1 hour 5 minutes *07/03/2025 at 5:34 PM response time 35	Y3244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016732	A. BUILDING: _____ B. WING _____	C 09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE SENIOR LIVING	2330 BRUCE STREET NEENAH, WI 54956

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y3244	Continued From page 12 minutes *07/07/2025 at 10:59 AM response time 35 minutes *07/10/2025 at 3:38 PM response time 1 hour 2 minutes *07/15/2025 at 3:28 AM response time 29 minutes *07/15/2025 at 12:52 PM response time 27 minutes *07/20/2025 at 4:40 PM response time 1 hour 20 minutes *07/20/2025 at 9:30 PM response time 26 minutes *07/22/2025 at 3:26 AM response time 55 minutes *07/23/2025 at 5:16 AM response time 31 minutes *07/23/2025 at 2:04 PM response time 1 hour 9 minutes *07/25/2025 at 8:25 PM response time 31 minutes *07/27/2025 at 4:10 AM response time 36 minutes *07/29/2025 at 8:38 AM response time 41 minutes *07/31/2025 at 3:31 AM response time 46 minutes *08/04/2025 at 3:05 PM response time 35 minutes *08/04/2025 at 5:07 PM response time 32 minutes *08/05/2025 at 11:17 PM response time 25 minutes *08/06/2025 at 3:39 AM response time 2 hour 9 minutes *08/06/2025 at 12:28 PM response time 37 minutes *08/07/2025 at 6:53 PM response time 1 hour *08/08/2025 at 3:34 PM response time 32 minutes	Y3244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016732	A. BUILDING: _____ B. WING _____	C 09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE SENIOR LIVING	2330 BRUCE STREET NEENAH, WI 54956

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y3244	Continued From page 13 *08/10/2025 at 4:47 AM response time 31 minutes *08/10/2025 at 12:19 PM response time 42 minutes *08/11/2025 at 10:15 PM response time 1 hour 14 minutes *08/14/2025 at 5:35 PM response time 25 minutes *08/15/2025 at 7:13 AM response time 32 minutes *08/17/2025 at 6:29 AM response time 39 minutes *08/18/2025 at 2:03 PM response time 28 minutes *08/21/2025 at 7:31 PM response time 29 minutes *08/22/2025 at 3:29 AM response time 30 minutes *08/22/2025 at 7:57 PM response time 40 minutes *08/25/2025 at 1:51 PM response time 34 minutes *08/28/2025 at 12:39 PM response 1 hour 33 minutes *08/30/2025 at 12:00 AM 6 hours 25 minutes *08/30/2025 at 9:14 AM response time 30 minutes *09/01/2025 at 12:48 AM response time 33 minutes *09/03/2025 at 12:44 PM response time 54 minutes *09/03/2025 at 7:45 PM response time 1 hour 4 minutes *09/05/2025 at 7:53 PM response time 40 minutes *09/06/2025 at 5:37 AM response time 37 minutes *09/06/2025 at 6:23 PM response time 57 minutes *09/07/2025 at 1:05 PM response time 49	Y3244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016732	A. BUILDING: _____ B. WING _____	C 09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE SENIOR LIVING	2330 BRUCE STREET NEENAH, WI 54956

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y3244	Continued From page 14 minutes *09/08/2025 at 2:51 AM response time 1 hour 58 minutes *09/08/2025 at 7:35 AM response time 1 hour 24 minutes *09/08/2025 at 5:54 PM response time 33 minutes *09/09/2025 at 3:09 PM response time 34 minutes *09/09/2025 at 8:14 PM response time 1 hour 2 minutes *09/10/2025 at 1:49 AM response time 32 minutes *09/10/2025 at 8:58 PM response time 35 minutes *09/12/2025 at 7:38 AM response time 35 minutes *09/13/2025 at 9:31 AM response time 42 minutes *09/13/2025 at 3:27 PM response time 38 minutes *09/14/2025 at 8:43 AM response time 1 hour 9 minutes *09/14/2025 at 11:22 AM response time 38 minutes *09/15/2025 at 7:09 AM response time 1 hour 7 minutes On 09/16/2025 at 5 PM, Surveyor interviewed Caregiver G about the call alarm system. Caregiver G explained when a resident pulls their call alarm cord located in their bedroom, the notification goes to the company phone carried by staff and a beeping sound is heard. The phone will display the resident's name, room number and location of the resident requesting assistance. Caregiver G verified the phone will continue to make a beeping sound every couple of minutes reminding staff the call-alarm has not been answered. Surveyor then questioned	Y3244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016732	A. BUILDING: _____ B. WING _____	C 09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE SENIOR LIVING	2330 BRUCE STREET NEENAH, WI 54956

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y3244	Continued From page 15 Caregiver G about the above statement made by Resident 1. Caregiver G stated, "I came in for my PM shift a few weeks ago and received the phone from the previous shift. When I looked at the phone, I noticed [Resident 1] had [his/her] call alarm on for over an hour and no one responded to it. When I went into [Resident 1's] bedroom [Family Member H] and [Resident 1] told me they had been waiting a long time for assistance." Surveyor then asked Caregiver G what assistance [Resident 1] needed when s/he entered the room. Caregiver G stated, "[Resident 1] needed [his/her] brief changed and help getting dressed." Caregiver G then stated, "Sometimes call-alarms do go longer if only one staff is in the building." On 09/16/2025 at 4:47 PM, Surveyor interviewed Executive Director I regarding the above call history report for Resident 1. On 09/17/2025 at 8:55 AM, Executive Director I acknowledged the call alarm reports documented multiple occurrences Resident 1 waited over 25 minutes and stated, "I talked to staff and management about the response times and I was told they respond but due to where the call light is placed some staff have a hard time reaching it to shut it off and have to wait for someone else to shut it off. I suggested moving [Resident 1's] call light or look at getting [him/her] a pendant." RESIDENT 2 On 09/16/2025, Surveyor reviewed the closed record for Resident 2. The record indicated Resident 2 was admitted to the facility on 11/16/2023 with diagnosis to include hypertension, diabetes and heart disease. Additionally, the record indicated Resident 2 was his/her own person and moved out of the facility	Y3244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016732	A. BUILDING: _____ B. WING _____	C 09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE SENIOR LIVING	2330 BRUCE STREET NEENAH, WI 54956

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y3244	Continued From page 16 on 06/30/2025. Resident 2's ISP dated 04/29/2025 indicated Resident 2 was non-ambulatory, utilized a wheelchair and required one staff for transfers with the use of a slide board. Additionally, the ISP indicated Resident 2 had a catheter, was incontinent of bowel and required assistance from staff for dressing, toileting, bathing and personal hygiene needs. The ISP also stated, "Skin Maintenance...Location of wound L foot...Mental Status: Verbally aggressive, demanding, uncooperative and disruptive...Behavior Care...Monitor Behavior: Resident is easily agitated...Behavior Monitoring." ***Surveyor noted Resident 2's ISP was silent to refusals of cares or interventions caregivers could utilize to encourage acceptance of cares. The ISP identified behaviors but did not include interventions to manage Resident 2's behavior that may be harmful to him/herself and others. On 09/16/2025, Surveyor reviewed Resident 2's "Progress Notes" from 03/01/2025 through 07/01/2025. The following notes were documented: ~03/10/2025- "...[Resident 2] told me to get out of [his/her] room and refused [his/her] bedtime cares. Management was notified." ~05/08/2025- "Resident returned to the facility via ambulance from hospital...Resident does have wounds to buttocks. Resident does have home health come in to do wound care..." ~05/09/2025- "...Skin- R foot discolored spot 1 coccyx wound..."	Y3244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016732	A. BUILDING: _____ B. WING _____	C 09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE SENIOR LIVING	2330 BRUCE STREET NEENAH, WI 54956

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y3244	Continued From page 17 ~05/17/2025- (Note written by Medication Aide F) "...Around 5:30 PM, I went into [Resident 2's] room to pass meds, [s/he] aggressively told me I didn't have to stand there and watch [him/her] take [his/her] meds. I told [Resident 2] I had to watch [him/her] at least put them in [his/her] mouth. [Resident 2] went on and told me no I didn't and to get out of [his/her] room and management should fire me because [s/he] doesn't like me...I walked out. I called [WC (Wellness Coordinator)-A] to inform [her/him] what happened, and I told [WC-A] I didn't feel comfortable caring for [Resident 2] if [s/he's] saying [s/he] doesn't like me. [WC-A] stated to [Resident 2] if [s/he] wanted any bedtime cares [s/he] is to get all cares before or at 8 PM before other caregiver leaves. [Resident 2] told [WC-A] [s/he] will not be going to bed at 8 PM so [WC-A] stated to [Resident 2] [s/he] would have to stay in [his/her] chair because other staff member leaves at 8 PM and I'm not allowed to give [Resident 2] care without another staff being present... [Resident 2] refused and threaten to call state." ~05/17/2025- (Note written by WC-A) "WC received a call from staff about 6 PM tonight about [Resident 2] being verbally aggressive towards [him/her]. WC explained to staff because the resident was being verbally aggressive [s/he] didn't have to do [his/her] cares by [her/himself]. WC explained to resident due to [him/her] being verbally aggressive [s/he] would have to go to bed before the 8 PM caregiver left, or [s/he] would have to sleep in [his/her] wheelchair because the staff did not feel comfortable doing [his/her] cares by [her/himself]. [Resident 2] stated, "I have the right not to go to bed at 8 PM." WC explained [Resident 2] does have a right to refuse to go to bed at 8 PM, however if [s/he] refuses to go to bed when there	Y3244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016732	A. BUILDING: _____ B. WING _____	C 09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE SENIOR LIVING	2330 BRUCE STREET NEENAH, WI 54956

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y3244	Continued From page 18	Y3244		

are 2 staff members than [s/he] is choosing to sleep in [his/her] wheelchair as staff does not feel comfortable putting [him/her] to bed by themselves. [Resident 2] stated, "I don't like [her/him]." WC explained again that is why there needs to be 2 staff present to do [his/her] cares. Resident 2 was quiet and did not say anything after that."

~05/18/2025- "...[Lead Medication Aide C] and [Caregiver L] were in the med room when resident came around the corner to go smoke and once at the door the resident said "[Lead Medication Aide C] you can stay in the med room and sit back down and don't worry about laying me down...You're a lazy [explicit]." [Resident 2] then went outside to smoke when [WC-A] came around the corner and went outside to talk to resident...[WC-A] walked into the building this morning witnessing [Resident 2] calling a staff member a [explicit]. [WC-A] went outside to explain it was inappropriate/disrespectful to call staff names. [Resident 2] stated, "I don't give a [explicit] what you have to say. [WC-A] said OKAY and went back into the building."

~05/21/2025- "On 05/20/2025 at about 3 PM, [Resident 2] called the police department...Staff asked the officers what was going on. The officers explained [Resident 2] called the police to do a welfare check as [Resident 2] felt [his/her] cares and needs were not being met. Officers talked to staff about the complaint, they went to talk to the resident. When officers came back to talk to staff, staff provided progress note reports and call light reports to the officers. Staff explained to officers [Resident 2] was taken care of over the weekend, however the resident got verbally aggressive with the staff working and was refusing cares from staff over the weekend."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016732	A. BUILDING: _____ B. WING _____	C 09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE SENIOR LIVING	2330 BRUCE STREET NEENAH, WI 54956

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y3244	Continued From page 19 ~05/27/2025- "WC (Wellness Coordinator) and ED (Executive Director) had a care conference with resident and care team on Friday 05/23/2025. WC and ED issued a 30-day notice due to resident refusing to let staff help [him/her] or do [his/her] cares. [Resident 2's] care team is currently looking for other placement at this time. APS (Adult Protective Services) was here on 05/22/2025 to follow-up on the complaint made by the resident." ~07/01/2025- "Resident moved out on 06/30/2025..." On 09/22/2025, Surveyor reviewed a facility self-report. The self-report indicated, "Resident behavior-Refusal of cares. On 05/20/2025, the police arrived at the facility to do a welfare check which was requested by [Resident 2]. [Resident 2] felt [his/her] cares were not being met, and [s/he] did not like the aide on. [Resident 2] has a history of behaviors and verbally abusing staff and is in the process of receiving a 30-day notice for refusal of cares. Staff pulled all progress notes and call light report from past weekend until current to show police officers they have been offering to help and do cares but [Resident 2] consistently refused help from staff. Police officer was going to fill out the complaint from [Resident 2] but was not concerned as the building and resident was clean/dry and odor free. Officers read all the progress notes from staff and the struggles they are having...Care plan updated, and care conference has been set up with [Resident 2's] care team to discuss the continued struggles the community is having with [Resident 2]." On 09/23/2025, Surveyor reviewed a police report	Y3244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016732	A. BUILDING: _____ B. WING _____	C 09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE SENIOR LIVING	2330 BRUCE STREET NEENAH, WI 54956

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y3244	Continued From page 20 dated 05/20/2025 which indicated, "...Officers were dispatched to the facility, for an elder abuse complaint. The reporting party, [Resident 2] would like to file a report [s/he] is being neglected. Officers made contact with [Medication Aide F]... [Medication Aide F] initially started discussing some issues surrounding [Resident 2] and [his/her] care. [Medication Aide F] described [Resident 2] as being difficult at times and even verbal with the staff. [Medication Aide F] stated there was some issues surrounding [Resident 2] refusing to go to bed over the weekend, which resulted in [her/him] sleeping in [her/his] wheelchair...However, at times [Resident 2] refuses or will not allow the help. [Medication Aide F] stated when this happens, [Resident 2] ends up sleeping in [her/his] wheelchair for the night. Officers had contact with [WC-A], [Registered Nurse-J], and [Business Office Manager-K]. Information was provided that [Resident 2] is a difficult client; however, they were surprised [s/he] called the police. Staff stated [Resident 2] has not made any complaints or comments today about [her/his] specific care. It was corroborated over the weekend, [Resident 2] was upset about not getting [her/his] medications in a timely manner. Staff stated they have a window from 4:00 PM-8:00 PM to give medications, but try to accommodate the 4:00 PM time, which is requested by [Resident 2]. [Medication Aide F] stated on 05/17/2025, [s/he] was helping another caregiver prepare dinner around 4:00 PM. [Medication Aide F] stated [Resident 2] wanted [his/her] medications, which [s/he] told [Resident 2] [s/he] was helping with dinner right now and reiterated of having the 4:00 PM-8:00 PM window, and [s/he] will get [Resident 2's] medications as soon as [s/he] is done helping. [Medication Aide F] stated around 5:30 PM [s/he] went into [Resident 2's] room to give	Y3244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016732	A. BUILDING: _____ B. WING _____	C 09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE SENIOR LIVING	2330 BRUCE STREET NEENAH, WI 54956

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y3244	Continued From page 21	Y3244		

[his/her] medications. [Medication Aide F] stated [Resident 2] made an aggressive comment [s/he] does not have to stand there and watch [him/her] take his meds. [Medication Aide F] stated [s/he's] responsible to watch any client to make sure they fully take their meds. [Medication Aide F] stated [s/he] talked to [WC-A] to inform [her/him] what happened and told [WC-A] [s/he] does not feel comfortable caring for [Resident 2] if [s/he] does not like [her/him]. [Medication Aide F] stated [WC-A] explained to [Resident 2] over the phone if [s/he] wanted any bedtime cares [s/he] is to get all cares before or at 8:00 PM, before the caregivers leave. [Medication Aide F] stated [Resident 2] said [s/he] was not going to bed at 8:00 PM and [s/he] would have to stay in [his/her] chair and [Medication Aide F] is not allowed to give [Resident 2] care without another staff being present...Officers made contact with [Resident 2]...Officers observed [Resident 2] to be wheelchair bound. [Resident 2] told officers [s/he] is not getting the appropriate care at this facility...[Resident 2] stated over the weekend, Saturday night (05/17/2025) going into Sunday morning (05/18/2025), [s/he] was forced to sleep in [his/her] wheelchair. [Resident 2] stated [s/he] had a bowel movement and defecated [her/himself]. [Resident 2] stated [s/he] pulled/pushed the call assist to get help from staff to get cleaned up. [Resident 2] recalls the time around 7:00 AM. [Resident 2] stated staff did not help [him/her] and made [him/her] sit in [his/her] feces for over 12 hours. [Resident 2] stated staff finally cleaned [him/her] when [s/he] went to bed after 8:00 PM. [Resident 2] stated initially [Lead Medication Aide C] came in to assist; however... [s/he] had to get help. [Resident 2] stated no one came back to help [him/her]. [Resident 2] stated [s/he] went down to the office and had some type of contact with staff...[Resident 2] stated [s/he] left

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016732	A. BUILDING: _____ B. WING _____	C 09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE SENIOR LIVING	2330 BRUCE STREET NEENAH, WI 54956

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y3244	Continued From page 22	Y3244		

and went outside to smoke and came back in around 10:30 AM. It appears; [Resident 2] never brought up to staff about the need to be cleaned up again. [Resident 2] stated, another worker who came on shift later in the day, helped [him/her] around 8:00 PM. [Resident 2] stated the worker cleaned [him/her] up and then got [Resident 2] into bed by [his/herself]...Contact was made with staff again. It was confirmed [Resident 2] activated [her/his] call assist at 06:44 AM Sunday morning, 05/18/2025...There was a 42 minute and 9 second response time once [Resident 2] activated it. Officer asked staff to confirm when [Resident 2] was, "cleaned up." Staff looked through this day's reports and did not observe it charted or documented...Officer asked staff if [Resident 2] can physically clean [her/himself] up after defecating [her/himself], they stated NO. [WC-A] brought up on several occasions [Resident 2] does not treat staff appropriately and is verbally abusive towards them. During this time, staff was not able to show any chart information of when they cleaned up [Resident 2]..."

No documentation was found in the medical record to show the provider attempted to determine the reason for Resident 1's refusals, offer or implement new interventions, or update the plan of care to manage the resident's behaviors and ensure the resident maintains good personal hygiene.

Review of the Resident 2's call alarm history from 05/14/2025 through 05/18/2025 showed the following wait times for assistance:

*05/14/2025 at 4:33 PM response time 57 minutes
*05/14/2025 at 7:22 PM response time 49

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016732	A. BUILDING: _____ B. WING _____	C 09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE SENIOR LIVING	2330 BRUCE STREET NEENAH, WI 54956

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y3244	Continued From page 23	Y3244		

minutes
*05/15/2025 at 1:52 PM response time 52 minutes
*05/18/2025 at 6:44 AM response time 42 minutes

On 09/15/2025 at 9 AM, Surveyor interviewed WC-A regarding the above information. WC-A stated Resident 2 called the police on 05/20/2025 because Resident 2 alleged s/he was neglected over the weekend on 05/17/2025-05/18/2025. WC-A stated, "We told the police what happened over the weekend and gave them all the paperwork they requested. Then APS showed up on Thursday 05/22/2025 and we gave APS all the paperwork and haven't heard anything since." WC-A indicated Resident 2 did not ambulate, transferred with one staff and a slide board and would refuse cares from staff [s/he] did not like. WC-A indicated on 05/17/2025 during the PM shift there were two staff working until 8 PM (Medication Aide F and Caregiver M) and from 8 PM until 6 AM, Medication Aide F was scheduled to worked alone. WC-A went on to say, "[Medication Aide F] called me on 05/17/2025 and said [Resident 2] was being vulgar, making derogatory comments and calling [her/him] names. [Mediation Aide F] told me [s/he] did not feel comfortable doing [Resident 2's] cares alone and [Resident 2] refused cares when [Caregiver M] was working. [Resident 2] refused cares and chose to sit up in the wheelchair all night. [Resident 2] targets multiple staff [s/he] likes and doesn't like, and it varies on the day and [his/her] mood."

On 09/15/2025 at 1 PM, Surveyor interviewed Lead Medication Aide C regarding Resident 2. Lead Medication Aide C confirmed Resident 2 was incontinent of bowel, had a catheter and did

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016732	A. BUILDING: _____ B. WING _____	C 09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE SENIOR LIVING	2330 BRUCE STREET NEENAH, WI 54956

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y3244	Continued From page 24	Y3244		

not like to wear incontinence briefs. Lead Medication Aide C also confirmed Resident 2 required assistance with personal cares and transfers, with the use of a slide board. Lead Medication Aide C stated, "[Resident 2] often refuses cares. On 05/17/2025, [Medication Aide F] told me [Resident 2] sat up all night in [his/her] wheelchair because [s/he] refused to let staff clean [him/her] up and put [him/her] to bed. Then on 05/18/2025, during the AM shift [Resident 2] refused to let me or [Caregiver L] clean [him/her] up or lay [him/her] down. During the AM shift on 05/18/2025, I could tell [Resident 2] was incontinent of bowel because [s/he] had a BM odor. [Caregiver L] and I kept offering throughout our shift to provide cares, but [s/he] refused." Surveyor then asked what staff are directed to do when [Resident 2] refuses care or has behaviors. Lead Medication Aide C stated, "We're supposed to chart [Resident 2's] refusals, re-offer cares, call [WC-A] or [ED-E]." Surveyor then asked if there were identified interventions in Resident 2's ISP for refusals and behaviors. Lead Medication Aide C acknowledged there were no identified interventions to manage Resident 2's behaviors or refusals of cares.

On 09/26/2025 at 10:30 AM, Surveyor spoke with ED-E regarding the above incident. ED-E confirmed on 05/17/2025, Resident 2 sat up in his/her wheelchair overnight because s/he refused to allow Medication Aide F to provide personal cares and put him/her to bed. ED-E further confirmed on 05/18/2025, during the AM shift Resident 2 continue to sit-up in [his/her] wheelchair, had a bowel movement and refused to allow staff to provide cares. Surveyor asked what staff were directed to do if Resident 2 refused cares and/or had behaviors. ED-E stated, "Staff are to allow [Resident 2] to cool

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016732	A. BUILDING: _____ B. WING _____	C 09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE SENIOR LIVING	**2330 BRUCE STREET NEENAH, WI 54956**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y3244	Continued From page 25 down, offer a cigarette, re-approach [Resident 2], call [WD-A], myself, or have a different staff attempt cares." ED-E verified the above ISP dated 04/29/2025 was the most recent ISP for Resident 2. Surveyor then asked if there were identified interventions in Resident 2's ISP for refusals and behaviors. ED-E acknowledged there were no identified interventions to manage Resident 2's behaviors or refusals of cares.	Y3244		